

INTEREST FORM

Pilot Study for Hospice Evaluation & Assessment Reporting Tool



Section 1: Contact Information

1. Personal Contact Information: *Please list personal contact information for your hospice's designated contact for this pilot study—list contact information of the person we should follow-up with regarding questions about this application, and who we should notify if you have been selected to participate.*

Name: _____

Job Title: _____

Phone: ()

Email Address: _____

2. Hospice Information:

Name of Hospice: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: ()

Website: _____

CCN: _____

NPI: _____

TIN: _____

Section 2: Hospice Facility Demographic Characteristics

3. Site of Service: *Mark all that apply.*

- | | |
|--------------------------|--|
| <input type="checkbox"/> | Hospice in patient's home/residence |
| <input type="checkbox"/> | Hospice in assisted living facility. |
| <input type="checkbox"/> | Hospice provided in Nursing Long Term Care (LTC) or Non-skilled Nursing Facility (NF). |
| <input type="checkbox"/> | Hospice provided in Skilled Nursing Facility (SNF). |
| <input type="checkbox"/> | Hospice provided in Inpatient Hospital. |
| <input type="checkbox"/> | Hospice provided in Inpatient Hospice Facility. |
| <input type="checkbox"/> | Hospice provided in Long Term Care Hospital (LTCH). |
| <input type="checkbox"/> | Hospice provided in Inpatient Psychiatric Facility. |
| <input type="checkbox"/> | Hospice provided in a place not otherwise specified. |
| <input type="checkbox"/> | Hospice home care provided in a hospice facility. |

4. Percent of Patients receiving Continuous Home Care: *if applicable.*

_____ % of patients who received CHC during their stay over the past year

5. Percent of Patients receiving General Inpatient Care: *if applicable.*

_____ % of patients who received GIP during their stay over the past year		
6. Where do you provide General Inpatient Care? if applicable.		
<input type="checkbox"/>	Hospice Owned Facility	
<input type="checkbox"/>	Contract with Other Facility	
<input type="checkbox"/>	Both Hospice Owned Facility and Contract with Other Facility	
7. Percent of Nursing Home Patients: if applicable.		
_____ %		
8. Average Daily Census:		
_____ patients per day		
9. Length of Stay:		
Average length of stay: _____ days		
Median length of stay: _____ days		
10. Percent of patients with length of stay of 7 days or less:		
_____ %		
11. List the top 3 primary diagnoses of population served. If possible, please include corresponding ICD-10 code for each diagnosis.		
Primary Diagnosis	Description	ICD-10 Code (optional)
#1 Primary Diagnosis		
#2 Primary Diagnosis		
#3 Primary Diagnosis		
12. Please indicate what type of population your hospice primarily serves:		
<input type="checkbox"/>	Urban	
<input type="checkbox"/>	Rural	
<input type="checkbox"/>	Frontier	
13. Please indicate whether your hospice is: Check only one response.		
<input type="checkbox"/>	For Profit	
<input type="checkbox"/>	Not-for-profit	
14. Please indicate whether your hospice is:		
<input type="checkbox"/>	Independently owned and operated	
<input type="checkbox"/>	Part of a chain or has multiple locations If you checked this response, please indicate the number of locations your hospice has: _____	

15. Please indicate your current payor mix:

<i>Payor</i>	<i>Percent (of patient days)</i>
Medicare (traditional fee-for-service)	
Medicare (managed care/Part C/Medicare Advantage)	
Medicaid (traditional fee-for-service)	
Medicaid (managed care)	
Other government (e.g., TRICARE, VA, etc.)	
Private Insurance/Medigap	
Private managed care	
Self-pay	
No payor source	
Unknown	
Other	

16. Percentage of served population that are dually-eligible beneficiaries (i.e. qualify for both Medicare and Medicaid)?

Dual eligible population: _____%

17. Please indicate the race distribution of the population that you serve:

<i>Race</i>	<i>Percent</i>
American Indian or Alaska Native	
Asian	
Black or African American	
Native Hawaiian or Other Pacific Islander	
White	

18. Please indicate the ethnicity distribution of the population that you serve:

<i>Ethnicity</i>	<i>Percent</i>
Hispanic or Latino or Spanish Origin	
Not Hispanic or Latino or Spanish Origin	

19. Please indicate the biological sex distribution of the population that you serve:

<i>Biological Sex</i>	<i>Percent</i>
Male	
Female	
Unknown	

20. Please indicate whether your hospice uses electronic records for

20a. Clinical/Medical Records?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
20b. Administrative/Billing Records?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

21. If you answered yes to either 20a. or 20b. above, please specify the name of the Electronic Record system used by your hospice.	
Name of EMR system used for clinical records:	
Name of EMR system used for administrative/billing records:	
22. Please list the approximate number of other hospices in your service area:	

23. Please indicate the # of employees and volunteers in your hospice:	
# Full Time Employees (FTEs):	_____
# Part Time Employees (PTEs):	_____
# Volunteers:	_____
Section 3: Quality Program Characteristics	
24. How many patient care-related indicators are currently in your hospice's QAPI Program? <i>Patient care-related indicators track quality/performance on patient care topics such as symptom management, care coordination, communication, etc.</i>	
_____ indicators	
25. Does your hospice have at least 1 person whose job (or part of their job) is to manage or coordinate quality measurement and/or improvement activities?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please list # of FTEs dedicated to quality initiatives _____
26. Are you participating in any structured performance measurement and/or quality improvement initiatives with other external organizations? <i>For example, NHPCO/NAHC initiatives, local collaboratives, EMR/Vendor initiatives such as QAPI Navigator?</i>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please list initiatives/collaboratives:

Please submit this form by email to hospice@rti.org by October 31, 2017.